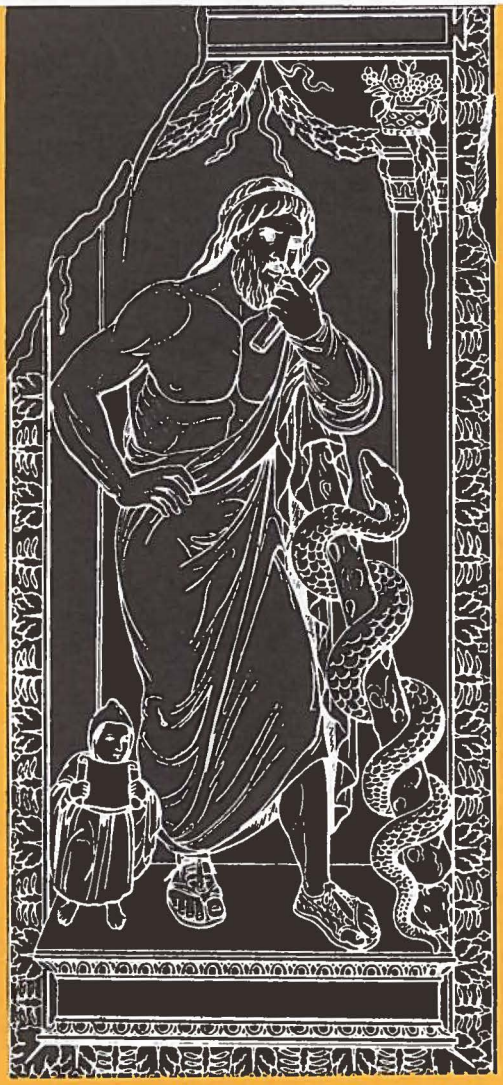
The Courier

OF THE GEORGE WASHINGTON UNIVERSITY HOSPITAL



FALL 1961

New Intern

How the Caduceus Went Wrong

Anthrax and Voodoo in Haiti

The Courier

ON OUR COVER stands the heroic figure of Aesculapius, the physician-god who dominated ancient Greek medicine for almost a thousand years. He was in mythology the father of Hygeia and Panacea, who are now medical bywords, and of Machaon and Podalirius, legends in the Trojan wars. His was an illustrious family.

Also on our cover, standing hopefully alongside his father, is the diminutive Telesphoros, the comparatively neglected member of the family. But although little known, Telesphoros has his own rightful claim to recognition, for he was the 'boy genius of healing,' the necessary specialist in convalescence. Wearing the hooded cape of the convalescent, he offers his particular skills in recuperation to those who have been ill.

Telesphoros has had some early and occasional acknowledgement, including the use of his sign in ancient Rome to indicate the residence of a physician. But he deserves more recent recognition, for his are skills not to be taken lightly.

To that end it is proposed that young Telesphoros be adopted by the School of Medicine as a mythical member of the junior class, symbolizing the student's early interest in and aptitude for the art of healing. It is especially fitting that Telesphoros be designated a student symbol and identified with this University's School of Medicine, the eleventh oldest in the nation, whose graduates have practiced the healing arts for more than five generations.

OF THE GEORGE WASHINGTON UNIVERSITY HOSPITAL

Published quarterly by the Women's Board of The Hospital

RICHARD C. THOMPSON, *Editor* MRS. JOHN PARKS, *Executive Editor*

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SUBSCRIPTIONS

THE COURIER is published by the Women's Board of the Hospital to tell the story of medical programs of The George Washington University. Persons may assist in this purpose as sustaining subscribers at $1.00 for one year and $2.75 for three years. Checks payable to The Courier should be mailed to the Board treasurer, Mrs. John M. Evans, 3303 Turner Lane, Chevy Chase, Maryland.

NEW INTERN

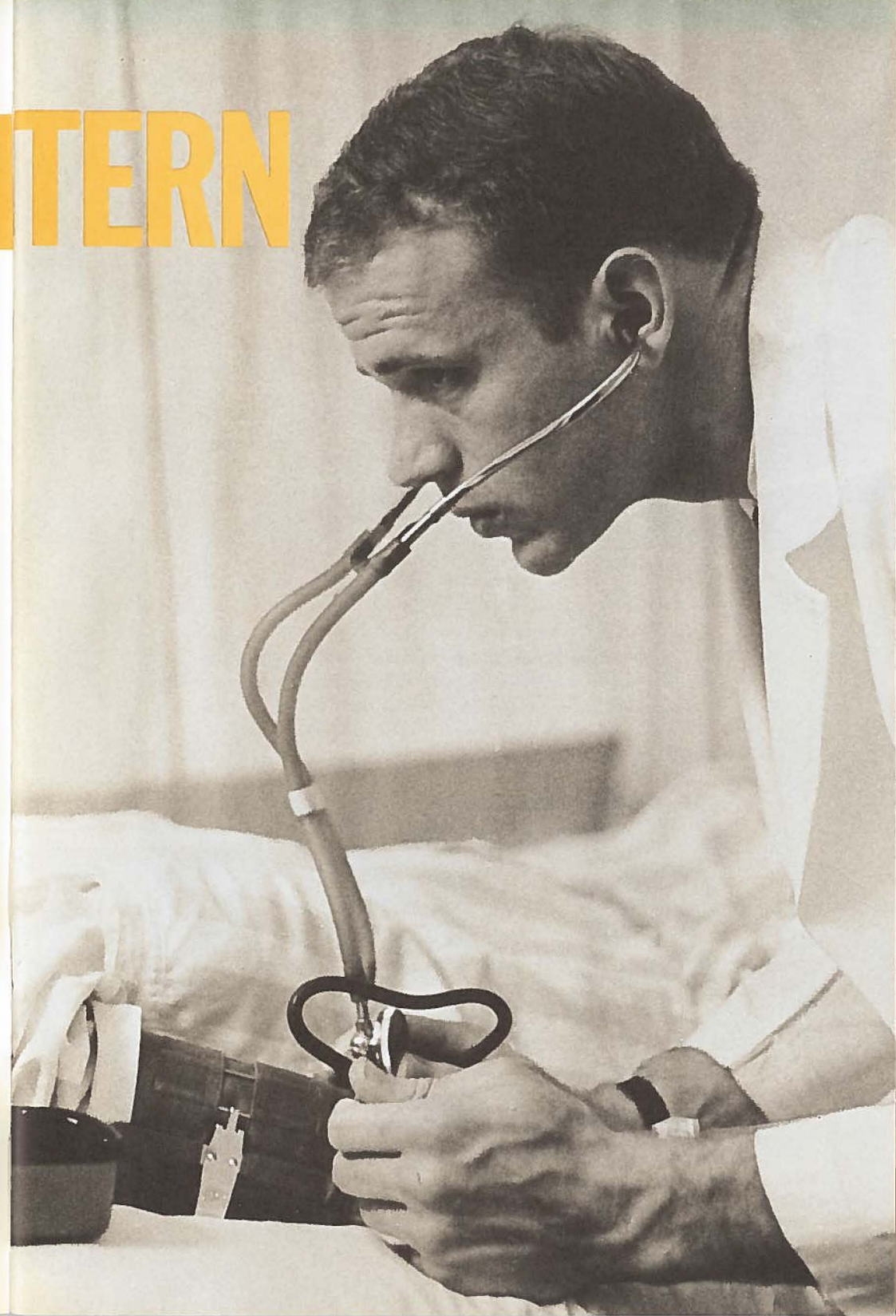
"My patient was a man in his late fifties—unconscious, cyanotic, rapid pulse and little pressure, all signs of cardiac shock. He had collapsed at work, the ambulance brought him to the emergency department, and they had sent him straight up here. He had no private physician; we were to do what had to be done. The resident physician and I set up the heparin and vasopressor and the EKG, and I thought to myself. . .

"You may be my first patient, but I've seen you a hundred times before—in my textbook on anatomy and the film on coronaries, in the cardiac clinic at the VA Hospital, when I was a senior student on the medical wards, and a dozen other times in a dozen other places. Your EKG says myocardial infarct, and your stethoscope sounds say the same. We know what you've got . . .and we know what to do.

"Of course it was an infarct—no great challenge in diagnosis—and his treatment and recovery were uneventful. But he *was* my first patient, he recovered under my care, and I signed his discharge diagnosis when he went home."

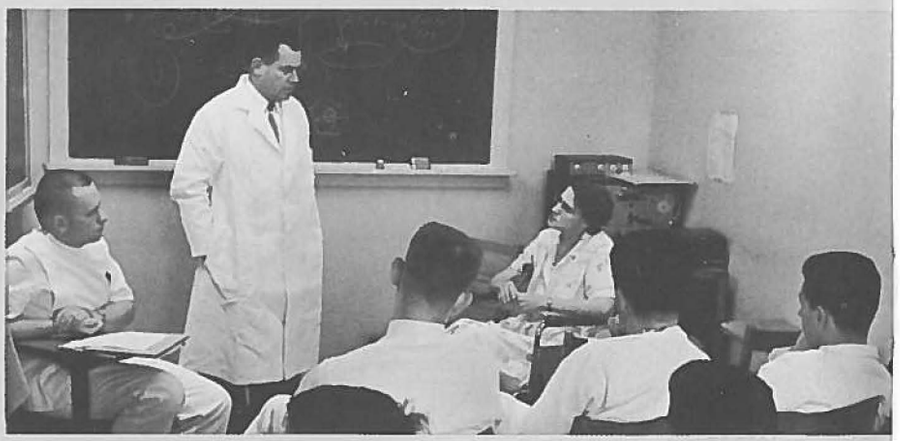
On July 1 of each year, at hospitals across the country, there are some 7,000 interns who encounter their 'first patient' under similar circumstances. Intentionally, they too will have seen him a hundred times before—in their books, in their classes, on the wards—for there is no profession which more directly prepares its practitioners than does Medicine.

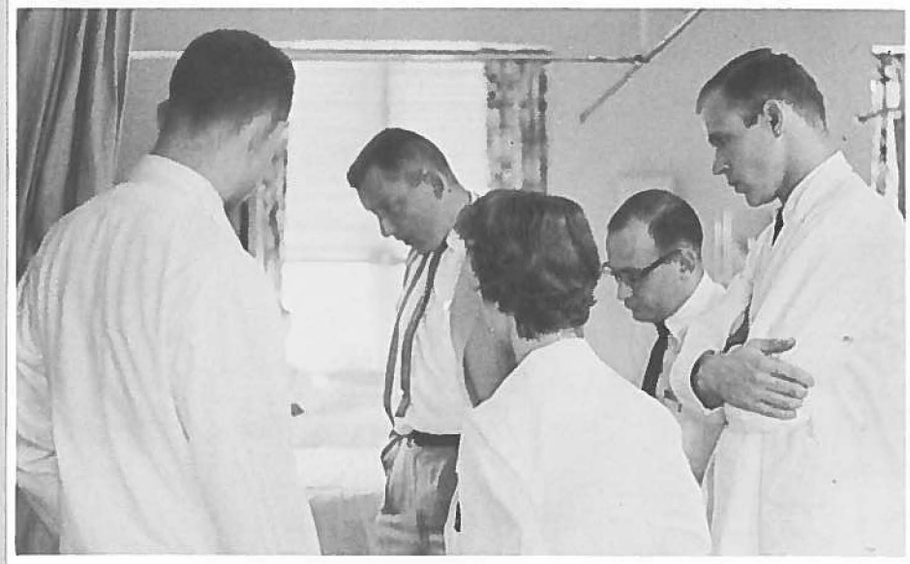
The internship permits the newly-graduated physician to use and to increase his medical skills in the controlled environment of the hospital. He is assisted and supervised by other, more experienced physicians. It is intended as an educational experience, a one-year bridge between medical school and medical practice. It is required



"When circumstances permit, the physician will first take his patient's medical history. By choice, it precedes any physical examination or laboratory test, for it can much affect the interpretation the physician will give the clinical findings. Patients are usually brought in by or with someone, perhaps a relative who can aid in giving the required information. Of course with an unconscious, unaccompanied patient, you do the best you can. In this photo, however, my patient is awake and cooperative as I take some notes prior to setting up his transfusion."

"Professor's rounds each Friday noon meant the presentation of a medically interesting patient before interns and residents on the service. Dr. Thomas McP. Brown, Professor of Medicine, here discusses long-term therapy for a woman arthritic patient (seated right)."





"We made attending rounds each weekday morning on 2C, stopping by each new admission and, when possible, other interesting patients. The attending physician saw both staff and private patients with us. When Dr. Orville W. Donnelly, Clinical Instructor, took rounds, we moved out at 8 o'clock sharp."

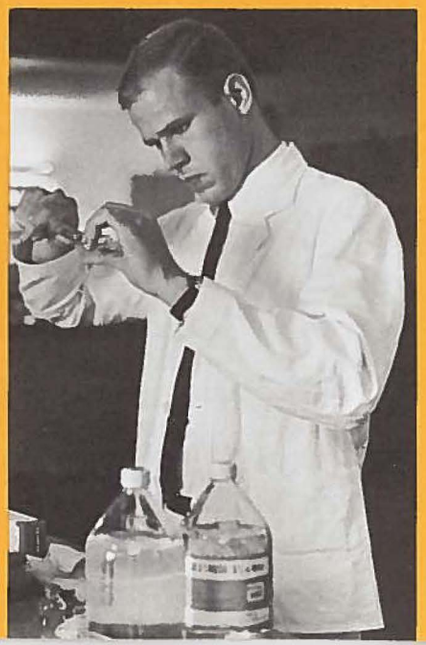
by law in most states, and increasingly has become the first step toward medical specialization.

Because it is a learning experience, the intern is likely to seek appointment to a large university hospital, which may seem to offer wider range of opportunity, or to a similar teaching hospital. With only 7,000 interns to fill 12,000 posts, many hospitals must operate without intern services, and this is of major concern to medical educators and hospital administrators.

In their senior year, medical students make known to the National Intern Matching Plan the hospitals where they wish to intern, based on their knowledge of differing hospital programs. The hospitals make known to the Plan those graduating seniors whom they desire as interns, based on the student's record in school. Through cross-matching, both student and hospital wishes are reconciled, using

"Patient specimens for lab determinations were taken before 8 a.m., then sent to the clinical labs. We sometimes did occult bloods and urinalysis on 2C and we could do smears in the hospital labs if desired. But the lab service was fast; we usually had reports on our patients back the same day, and stat results even faster.

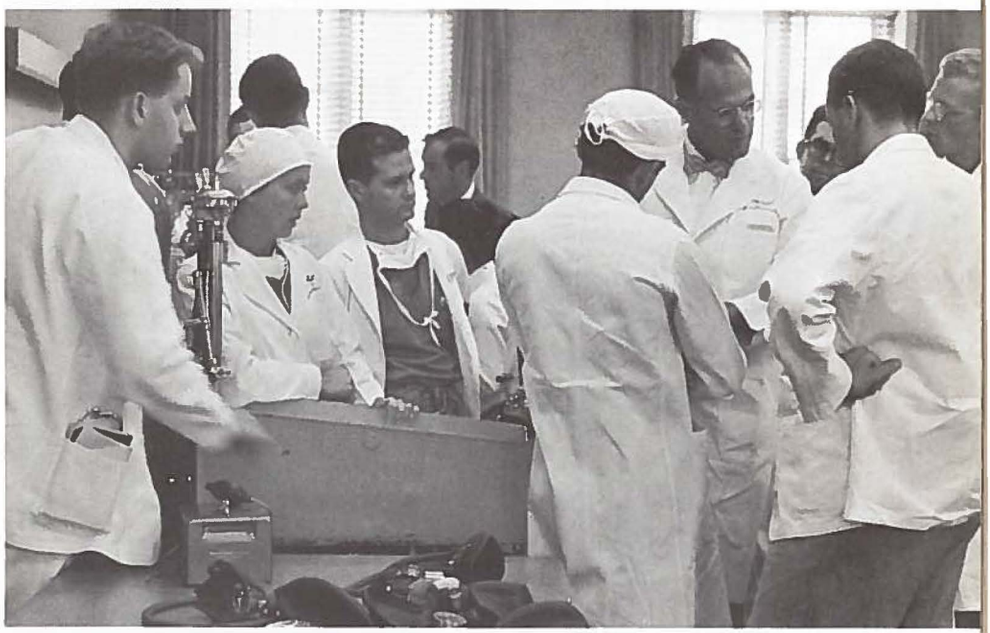
"Much of our day was given over to ward work on 2C; the necessary continuing details of patient care. Dr. Irvin Herman (the other intern) and I each had half the patients on the floor, supervised by Dr. Constance Lapointe, the 2C resident. We took turns working up new admissions, to keep the half-and-half balance, and we slept in the Hospital's intern quarters on alternate nights to be on call to our floor. 2C was a general medical floor, male and female, and we had many very ill patients and some who were critical. Here I prepare intravenous potassium for an elderly woman patient, comatose from a stroke, who required a continuous I.V. drip."



first choices and then alternate choices on down the line. Before he graduates, each student will have been appointed as intern to a hospital which wanted him and where he wished to serve.

Intern staffs at hospitals across the country change each July 1, a phenomenon little known to persons outside Medicine. This could be opportunity for great confusion—7,000 new physicians presented with the care of several million ill and injured persons. But it is not, because these physicians will be doing that for which they have been

"The Hospital was anxious that we learn the services and facilities available for our patients. During the first two weeks, there were lectures and demonstrations for the entire house staff on lab procedures, medical records, x-ray services, admissions, and here, inhalation therapy. Dr. Seymour Alpert (right), Professor of Anesthesiology, describes resuscitation and other inhalation equipment used throughout the Hospital."



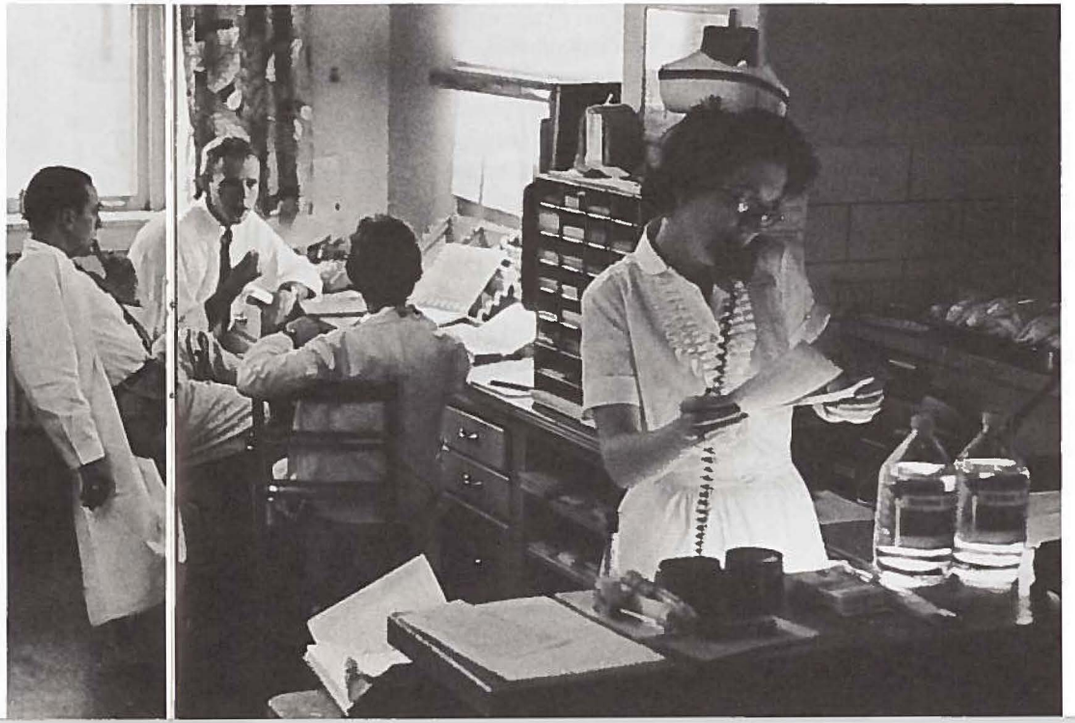
"Bill Carroll and I run through clinical lab reports which the messenger has just brought to the 2C station. Bill is a fourth-year G.W. medical student; he knew his way around the Hospital and helped me find mine."

preparing for four and more years, guided by the skill and knowledge of more experienced colleagues.

Among the twenty-three interns reporting for duty July 1 at the George Washington University Hospital was Paul Douglas Johnson, M.D. He had received his medical degree from the University of Kansas just 25 days before. He had learned of the Hospital's intern program from a former resident physician during summer Navy duty, and it was his first choice for appointment. With an interest in cardiology and internal medicine, he began his rotation through the Hospital's medical service on floor 2C.

Dr. Johnson is shown in various clinical and learning situations during his first days on 2C; the captions are his comments.

"The experience of attending physicians, of residents and others on the staff was available to us when needed, both at scheduled rounds and meetings and also as we encountered these physicians about the Hospital. Here Dr. William F. Morrissey, chief resident in medicine (at left), Dr. Constance Lapointe, our 2C resident, and I consider the treatment we shall use for a young woman with renal tuberculosis just admitted to the floor. She is a staff patient, meaning that she has no private physician and will be under the care of the Hospital resident staff. Telephoning at right is Miss Eileen Doherty, nurse on 2C."



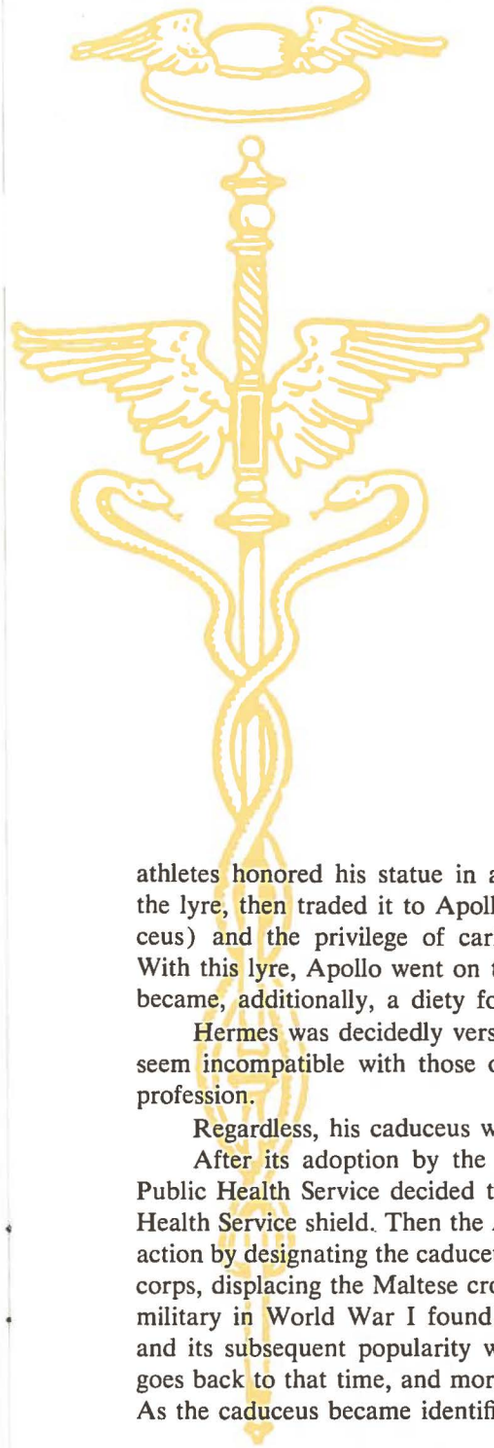
HOW THE CADUCEUS WENT WRONG

It was the American Army which really led Medicine astray.

In the 1850's, military hospital stewards in this country felt the need for a symbol which would indicate the nature of their skills and identify them as non-combatants on the field of battle. They chose the caduceus, the "Herald's Wand" from Greek mythology used by Hermes, messenger for the gods, to gain safe-conduct as he went about his business. The caduceus had also acquired a medical connotation through use by certain medical groups and book printers in Europe.

This would seem to have been a reasonable selection.

In the confused thinking of mythology, however, Hermes had business other than being celestial messenger. He was the god of trade and commerce, of games of chance, thievery, lawful and unlawful profits, and of eloquence and persuasion. He was the protector of travelers and the guide who led the souls of the dead to their final place of rest. His winged hat and feet gave him such speed that



After 100 years

Medicine still protests

this unlikely

deus ex machina

athletes honored his statue in ancient Olympic games. He invented the lyre, then traded it to Apollo for a golden wand (the first caduceus) and the privilege of caring for the herd of heavenly cattle. With this lyre, Apollo went on to become god of music, and Hermes became, additionally, a diety for shepherds.

Hermes was decidedly versatile, but some of his interests would seem incompatible with those of hospital stewards and the medical profession.

Regardless, his caduceus was on its way.

After its adoption by the hospital stewards, the United States Public Health Service decided to include the caduceus in the official Health Service shield. Then the Army in 1902 compounded its earlier action by designating the caduceus as the collar insignia for its medical corps, displacing the Maltese cross used before. The expansion of the military in World War I found the caduceus appearing everywhere, and its subsequent popularity with the non-medical public probably goes back to that time, and more recently, to the Second World War. As the caduceus became identified as the symbol of Medicine, it was

This heroic version of Aesculapius makes his son Telesphoros almost diminutive. Telesphoros wears the hooded cape of the convalescent, as befits a specialist in recuperation.

adapted and used commercially (Hermes, god of business) by medical suppliers, health groups, drug manufacturers, book publishers and practically everyone close to Medicine.

Everyone, that is, except the physicians. They like it hardly at all.

The reason is that physicians have their own nominee, also borrowed from Greek mythology and also possessed of a snake-entwined wand. His name is Aesculapius (or Asklepios), he was the son of the god Apollo, and he learned his medical skills from the centaur

Chiron (chirurgeon became surgeon). As Apollo's son he should probably have inherited the caduceus which Apollo had traded earlier to Hermes. But that matters little, because he soon acquired a staff of his own.

Now presumably Aesculapius and his knobby staff had been as available to the U.S. Army as was Hermes and his winged caduceus, but through circumstance it was Hermes (god of chance) who was chosen, thus fastening the caduceus upon the military and upon medicine.

In the easy transitions of mythology, there may well have been a person Aesculapius, whose knowledge of medicine caused his name to be continued after death through elevation to divinity. He was supposedly struck down by a thunderbolt from Zeus because his medical skill was interfering with heaven-sent disease and mortality.

As the benign god of healing in the Greek hierarchy, Aesculapius became the central figure in an extensive system of religion and therapy which was to exist for several hundred years. Some 200 temples were established in his name throughout Greece and the ancient world, operated by guilds (at first, families) of priest physicians (Asklepiades) trained in the arts and mysteries of medicine. Elaborate temple facilities with long, open porticos were built over mineral water springs, in mountain areas, at the seashore and in other healthful

Worked into this drawing of the staff of Aesculapius is the maxim that "Life is short, Art is long, Experience difficult."

locations. The ill and injured, over a period of several days, would combine religious rites with fasting, bathing, massage and induced sleep (incubation). Temple sleep and dream therapy were important, with priestly interpretation of the dreams required to learn what the god had revealed. It was faith healing and psychotherapy with some elements of science, but it was the best which the times could provide.

Prior to therapy, patients would arrive with models of organs and areas of the body to be treated; then when the cure had been effected, these diagnostic aids would be left at the temple as testimonials (votives) to the power of the god. Fees were related to ability to pay: a young boy offered ten dice for his treatment, a Greek noble, $10,000 for his restored eyesight.

Most elaborate of the temples in Greece were at Epidaurus and at Cos, the latter the birthplace of Hippocrates, Father of Medicine. Roman travelers carried the name of Aesculapius back to their city, and his divine intervention in a plague there about 300 B.C. made him a healing diety in Roman mythology.

The children of Aesculapius were also noteworthy. Among his daughters in mythology were Panacea, who had complete knowledge of medication and remedies, and Hygeia, the goddess whose concern became public health. Two older sons, Machaon and Podalirius, were taught medicine by their father and, as described in the *Iliad,* served in the wars against the Trojans. Aesculapius, proud father, is frequently shown with his small son Telesphoros, the "boy genius of healing" who specialized in convalescence and recovery, but whose appearence belies this skill.

It is with Aesculapius, therefore, and not Hermes, that the physician would be identified. Aesculapius treated the sick and injured, founded a system of hospital temples, taught his medical knowledge to others. He used psychotherapy and scientific medicine to the extent that it was known. Perhaps he did some medical research. His fees were reasonable; he would have been a good family doctor. He had none of the aberrations of the unlikely Hermes, no conflict of interests, no odd responsibilities for shepherds and commerce and games of chance.

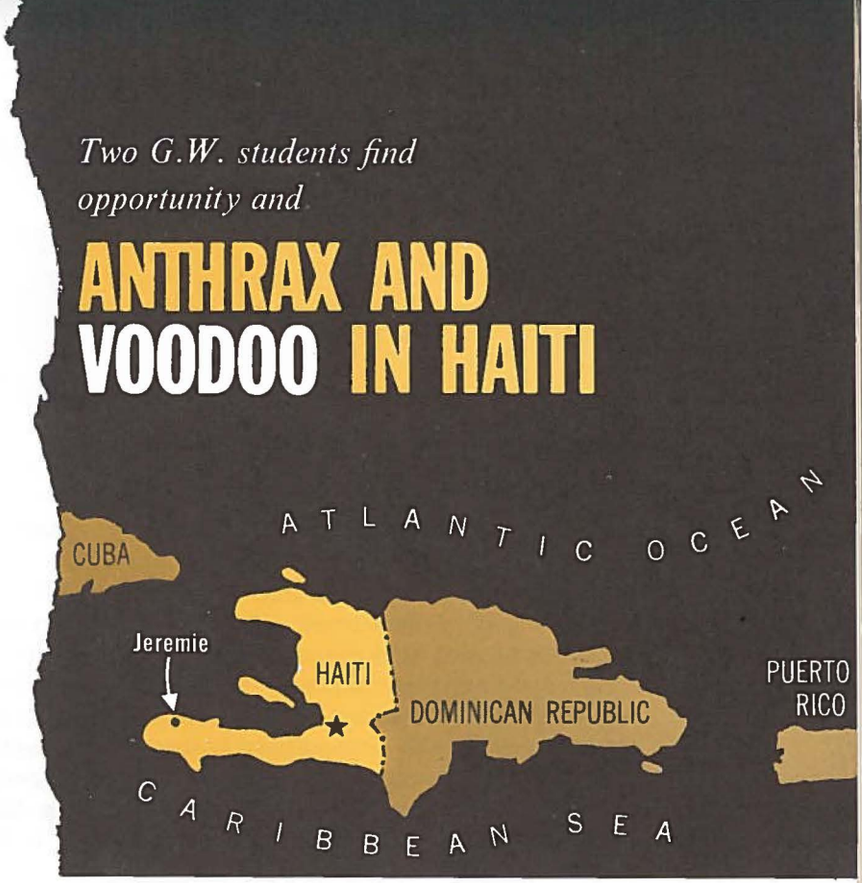
Aesculapius was the good physician, the practitioner of medicine, the god of health and healing; all honor to his name.

But it is the unwelcome sign of Hermes which is used: Hermes the trickster, the persuader, the elusive god of profit.

And he never even had a practice.

Two G.W. students find opportunity and

ANTHRAX AND VOODOO IN HAITI



Strung across the top of the Caribbean eastward from Cuba are those various islands, large and small, which make up the West Indies group. Among them is Hispaniola, whose eastern two-thirds form the Dominican Republic and whose western third is Haiti. Near the tip of the long mountainous peninsula which runs a hundred miles out from the mainland is the small port-town of Jeremie, population about 15,000. And at remote Jeremie is a 120 bed regional hospital operated by Medico, the organization which seeks to take good medical care to wherever it is needed in the world.

Jeremie is isolated; it can be reached after a two-day trip over treacherous mountain roads, or by once-a-week trading ship, or by

Kathryn Hoffman

Michael Hoffman

infrequent government airline. Starting point is the capital city of Port-au-Prince.

It was to the Jeremie hospital that Kathryn and Michael Hoffman, wife and husband senior medical students, traveled this past June on a summer grant from the Smith Kline and French Laboratories, pharmaceutical manufacturers. SKF foreign fellowships, administered by the Association of American Medical Colleges, are awarded competitively on a national basis, according to the merit of proposals submitted by requesting students. The grants provide opportunity to enhance the medical students' training: to have unusual clinical experience; to treat disease not common here; to see medicine practiced in other cultures.

Michael Hoffman writes—

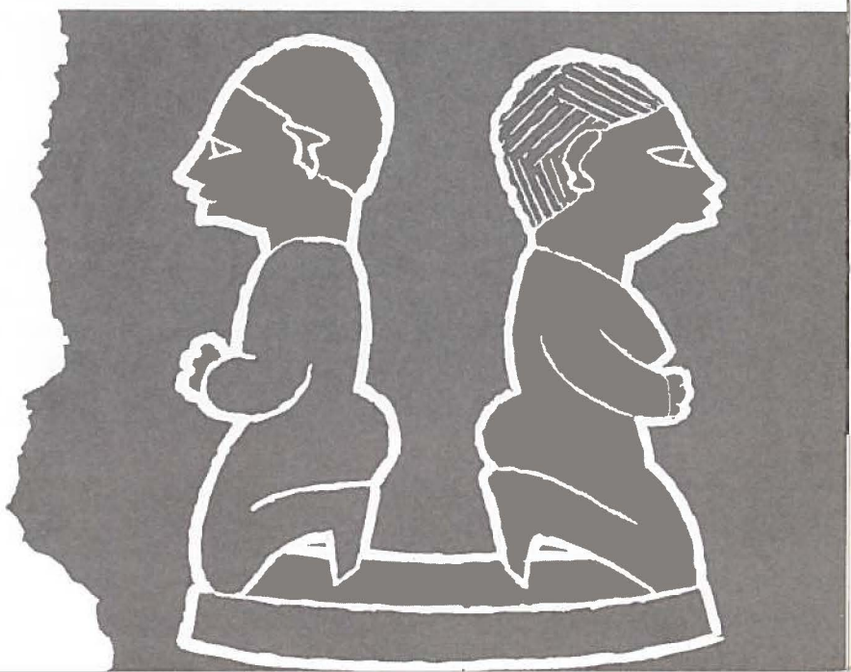
Haiti is an undeveloped country, with a literacy rate of about 15% (which is improving through government education). It is the only French-speaking nation in the Americas, actually using the Creole-French dialect. Roman Catholicism is the state religion. It is densely populated; most of the people work on small farms and seem to live on the products of their garden patches and the abundant wild fruits. Coffee is grown for export; rice, beans, sweet potatoes, breadfruit and mangoes are largely for home consumption.

The maladies of Haiti, as we saw them at the Saint Antoine Hospital, are those of the undeveloped tropical country—malaria, tuberculosis, amebiasis and worm infestation, with high incidence of yaws, syphilis and gonococcal infections. A low standard of living and inadequate medical care (about one physician for 20,000 persons) brought many patients presenting late complications of untreated disease: massive tubercular cavitation, paresis, anthrax (a severe bacterial disease of animals, sometimes found in man), scrofula and limb destruction by tropical ulcers. With no mass innoculation programs, there is considerable tetanus, typhoid and diphtheria.

We saw few patients with hypertension, strokes or coronary artery disease, probably because the diet is low in fat and high in carbohydrate. Then too, a short life expectancy (maybe 50 years) prevents much of the population from reaching that age where the degenerative diseases appear.

More than 90% of the Haitian population is descended from African Negroes brought over in the 17th and 18th centuries by Spanish and later, French colonists. With them came voodoo (in

Double fetish, male and female



Creole, voudou, and in the original African, vodu), and these rites of sorcery are still widely practiced in Haiti. Voodoo makes much of spirits and the fetish, a natural or constructed object which has magical powers for good or evil, depending on the intentions of the user. Of course, it was never voodoo vs. medicine—but I am sure that some of our patients had seen their voodoo doctor before they came to see us.

The Saint Antoine Hospital had 120 beds, and a dispensary which housed the pharmacy, laboratory and outpatient department. There were 30 pediatric beds, 30 obstetric, 40 medical-surgical, and a 20-bed tuberculosis ward. On the staff were six young and well-trained Haitian physicians and six Medico physicians, ten Haitian nurses, five American nurses and an x-ray and laboratory technician. The Medico group included a surgeon, an internist, an obstetrician, a pediatrician and an anesthesiologist.

Laboratory facilities were adequate for routine bloods, urines and stools; there was a three-week report time needed for tissue pathology. The well-equipped operating room was used three days a week for general surgery; three days for ear-nose-throat and ophthalmological surgery. Inadequate electrical power (a real need in Haiti) prevented our using the x-ray equipment.

Outpatient clinics were held six days a week in medicine, surgery, pediatrics and obstetrics, and we saw about 30 patients daily. The clinics also acted as admitting services for the Hospital wards, which were crowded.

Our duties were like those of an intern in the States: first or second assistant in surgery on alternate days, then rotation through the outpatient clinics. We saw and treated patients in the clinics, backed by ready consultation with any staff physician as a diagnostic or therapeutic problem arose. Teaching rounds were conducted twice weekly for the entire group.

What we learned at Jeremie—and this is certainly true of other similar areas of the world—is that the physician will find he can practice very good medicine and use modern drugs and current procedures. But he may not have access to elaborate diagnostic aids and other refinements which were available to him at home. He will find himself depending on elementary physical diagnosis, as taught him early and often in medical school. He will use the skills he can take with him. He will develop sharpened sensibilities, however, and the reassuring awareness that it is the ability of the physician which still counts most in medicine.

Hospital Program Places First Administrative Group

Twenty-eight graduate students of hospital administration have completed their academic studies at the University and begun a year of work-experience in various hospitals across the country. This is the first group of administrative residents placed by the University's teaching program in hospital administration, which was established in 1959 in the School of Government, Business and International Affairs. Students will be granted their master's degree at the completion of their hospital residencies. Professor Frederick H. Gibbs directs this program.

First row: Frank D. Whalen, Ramiro Walker Mendoza, Frank P. Iacobell, Professor Frederick H. Gibbs, Andrew R. McKillop, Leonard P. Hofer, Theodore I. Jongerius.
Second row: Charles W. B. Gravett, Noel Woodley, Henry Paul Bunting, Daniel G. Richardi.
Third row: Frederick J. Kessler, Norman M. Karshmer, William A. Parker, Leonard J. Muller, Norman C. Crews, Jr.
Fourth row: Richard G. Hill, Otto G. Spamer, Jr., David A. Musgrave, George L. Reynolds, Fernando S. Rojo, Wallace M. Dow, Robert J. Allen, Alvin M. Powers.
Fifth row: Robert M. Carr, Travis C. Glenn, Joel T. Kass, Walter G. Harden

Honors to Medical School . . .

During their four years of study, medical students at most schools across the country are given two series of standardized tests in the various medical specialities. Part one is given by the National Board of Medical Examiners in the sophomore year, part two in the senior year. A recent report from the National Board states that all members of the 1961 senior class at George Washington passed the part two examinations given last spring, and that the class ranked seventh in the nation. Taking note of this achievement, President Thomas H. Carroll has commended the members of the School of Medicine faculty, whose quality of teaching helped make these results possible.

. . . and Hospital

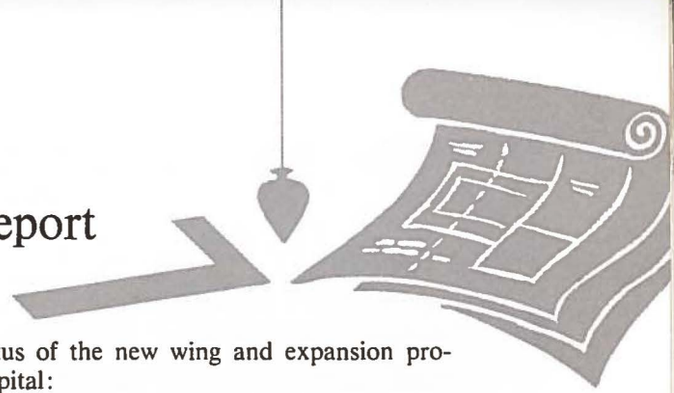
The George Washington University Hospital has been cited by the Secretary of Labor for its excellent safety record during 1960, marked by its placing first among District of Columbia hospitals with an award from the National Safety Council and the American Hospital Association.

Psychiatry and Marriage Series

The Department of Psychiatry of the School of Medicine is offering a series of lectures discussing the marital problems which are commonly encountered in the practice of medicine. The eight lectures will be held each Wednesday evening, October 4 through November 22, at 8 p.m. in the main conference room of the University Hospital. Fee for the course is $40, and the series is co-sponsored and accredited by the American Academy of General Practice.

The lectures are as follows: October 4, Practice of Medicine and Marriage Problems; October 11, Neurotic Marriage; October 18, Sex and Marriage; October 25, The Child in Marriage Conflict; November 1, Chronic Illness and Marriage Adjustment; November 8, Effect of Emotional Depression on Marital Problems; November 15, Role of the General Practitioner in Marital Conflict; November 22, Role of Obstetrician and Gynecologist in Marital Conflict.

Hospital Construction Report



This is the present status of the new wing and expansion program for the University Hospital:

The Secretary of Health, Education and Welfare has submitted to the Congress a bill by which Federal funds will be made available to finance up to half the cost of this new Hospital construction. The bill has been introduced in both Houses of Congress. The Evening Star newspaper reports that Chairman Alan Bible of the Senate District Committee has indicated that he intends to consider this bill in the next session of Congress, representing $3 million in Federal funds for the University Hospital construction.

Meanwhile the University and Hospital administration is studying reports from the consultant firm which has been surveying the space, facility and other needs of the Hospital, its departments and services. This survey will permit better evaluation for present and future planning and for the best utilization of the new construction.

AACP Borrows Dean Bliven

Dr. Charles W. Bliven, Dean of the University's School of Pharmacy, has been appointed executive secretary-treasurer of the American Association of Colleges of Pharmacy. His appointment, effective August 1, 1961, makes him the first full-time officer of the Association.

Dean Bliven will be on leave-of-absence from the University during the present school year. In his absence, Assistant Dean Robert M. Leonard will serve as chief administrative officer for the School.

The A.A.C.P. is an association of colleges of pharmacy and there are presently seventy-seven schools as active members in the United States, Puerto Rico and the Philippines, with three Canadian schools as affiliate members. The Association was first organized in 1900 and it is concerned with education and research in pharmacy. Dr. Bliven has served the Association as president (1959-60), as vice-president, secretary-treasurer and executive committee member.

THE COURIER; Fall 1961; sources and credits:

NEW INTERN—*Photographs and text by Richard C. Thompson.*

HOW THE CADUCEUS WENT WRONG—*Text by Richard C. Thompson; illustrations from the Bettmann Archives.*

ANTHRAX AND VOODOO IN HAITI—*Text by Michael Hoffman; illustration by Neil McKnight.*

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